STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055141	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Post Acute Center	11900 Ramona Boulevard El Monte, CA 91732

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report allegations of abuse for three of five sampled residents (Resident 3, Resident 4, and Resident 9) to the State Agency within two hours, in accordance with the facility's policy and procedure (P&P) titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, revised April 2025.These failures resulted in the delay of notification to the State Agency and had the potential for Resident 3, Resident 4, and Resident 9 to be subjected to abuse while at the facility.Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 6/2/2025 and readmitted Resident 3 on 7/3/2025 with diagnoses which included acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems), and urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 3 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 3 was independent with dressing, toileting, and personal hygiene. b. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on 6/15/2022 and readmitted Resident 4 on 7/28/2025 with diagnoses which included acute kidney failure, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and muscle weakness. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had no impairment in cognitive skills. The MDS indicated Resident 4 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing, lower body dressing and toileting hygiene. The MDS indicated Resident 1 required supervision (oversight, encouragement or cuing) from staff for oral and personal hygiene. c. During a review of Resident 9's AR, the AR indicated the facility admitted Resident 9 on 12/29/2023 and readmitted Resident 9 on 9/1/2024 with diagnoses which included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), muscle wasting and atrophy (loss of muscle tissue), and hypertensive chronic kidney disease. During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 had no impairment in cognitive skills. The MDS indicated Resident 9 required substantial/maximal assistance from staff for bathing, lower body dressing and toileting hygiene. The MDS indicated Resident 9 required supervision from staff for oral and personal hygiene. During an interview on 12/29/2025 at 12:30 PM with Certified Nursing Assistant (CNA) 4, CNA 4 stated CNA 2 used to be the staff person assigned to give residents (in general) showers. CNA 4 stated around one or two months ago, an allegation was made against CNA 2 that CNA 2 was inappropriate toward a resident (unidentified). CNA 4 stated CNA 2 was absent from the facility for a week or two during the investigation of the allegation. CNA 4 stated when CNA 2 was allowed to work at the facility again, CNA 2 was not assigned to give residents (in (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	general) showers anymore. During an interview on 12/29/2025 at 1:17 PM with CNA 1, CNA 1 stated another CNA (unidentified) told CNA 1 that CNA 2 was overheard talking to Resident 3 about the size of Resident 3's penis. CNA 1 stated CNA 1 did not immediately report the allegation against CNA 1 to the Director of Nursing (DON) or the Administrator (ADM). CNA 1 stated CNA 1 also witnessed on another occasion, CNA 2 acting inappropriately toward Resident 4. CNA 1 stated CNA 2 was standing in front of Resident 4 in the hallway. CNA 1 stated CNA 2 grabbed CNA 2's breasts and asked Resident 4, They look good, right? CNA 1 stated CNA 1 considered CNA 2's behavior to be sexual harassment toward Resident 4. CNA 1 stated CNA 1 did not report this incident to the DON or the ADM because CNA 2 was known to behave that way in the past. CNA 1 stated CNA 1 told Licensed Vocational Nurse (LVN) 1 about CNA 2's inappropriate behavior towards Resident 4 a few days later, around 11/18/2025. CNA 1 stated LVN 1 then reported CNA 2's inappropriate behavior towards Resident 4 to the ADM. During an interview on 12/29/2025 at 1:55 PM with the ADM, the ADM stated CNA 1 informed the ADM that CNA 2 had made a gesture to herself in front of Resident 4. The ADM stated the ADM sent CNA 2 home when the ADM was made aware of CNA 2's alleged inappropriate behavior. The ADM stated the ADM investigated the allegation and determined the incident was not abuse. The ADM stated the ADM did not report the allegation to State Agency because the ADM had already investigated the allegation and determined there was no abuse. During an interview on 12/29/2025 at 2:27 PM with CNA 2, CNA 2 stated there was an occasion in the past (date unknown) when the ADM called CNA 2 to the ADM's office and asked CNA 2 if CNA 2 had been inappropriate towards a resident. CNA 2 stated the ADM did not specify who the resident was. CNA 2 stated CNA 2 was sent home right away. CNA 2 stated CNA 2 was not allowed to work for a week while the facility was investigating the allegation against CNA 2. CNA 2 stated the Director of Staff Development (DSD) or the ADM called CNA 2 to inform CNA 2 when CNA 2 could return to work. During an interview on 12/30/2025 at 10:30 AM with LVN 1, LVN 1 stated sometime in October or November of 2025, CNA 1 informed LVN 1 of CNA 2's inappropriate behavior toward Resident 4. LVN 1 stated LVN 1 told CNA 1 to report the allegations to the ADM. LVN 1 stated LVN 1 did not report the allegations of abuse to the State Agency. LVN 1 stated LVN 1 also reported to the ADM in October 2025, that Resident 9 had reported to LVN 1 that CNA 3 was aggressive toward Resident 9. LVN 1 stated LVN 1 had not reported Resident 9's allegation against CNA 3 to the State Agency. During an interview on 12/30/2025 at 11 AM with Resident 9, Resident 9 stated CNA 3 was very rude. Resident 9 stated when Resident 9 reminded CNA 3 to do something, CNA 3 would be angry. Resident 9 stated CNA 3 told Resident 9 to shut up. Resident 9 stated CNA 3 would argue with Resident 9. Resident 9 stated Resident 9 reported CNA 3's behavior to LVN 1. During an interview on 12/30/2025 at 4:15 PM with the ADM, the ADM stated the ADM was not aware of Resident 9's allegations against CNA 3. During a review of the facility's P&P titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, revised April 2025, the P&P indicated, If there is an allegation or suspicion of abuse, the facility will make a report to the appropriate agencies as designated by State and Federal laws. The P&P indicated, 1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will:a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but: Not later than two (2) hours after the allegation is made if the events that cause the allegation involve abuse or results in serious bodily injury Not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury2. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to:a. The Administrator (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the Facilityb. The State Survey Agencyc. Adult Protective Services (as appropriate)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its policy and procedure (P&P) titled, Fall Management System, for two of three sampled residents (Resident 6 and Resident 7) when: a. Resident 6's bed sensor pad alarm (an assistive electronic device that makes alerts/sounds to warn caregivers when the resident tries to get up from the bed) was in the off position while Resident 6 was in Resident 6's bed. b. The facility's Interdisciplinary Team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the resident) failed to implement new interventions to address Resident 7's falls on [DATE] and on [DATE]. The IDT also failed to update Resident 7's care plan following Resident 7's falls on [DATE] and [DATE]. These failures had the potential to result in Resident 6 and Resident 7 sustaining injury and/or harm due to falling while in the care of the facility.Findings: a. During a review of Resident 6's admission Record (AR), the AR indicated the facility admitted Resident 6 on [DATE] and readmitted Resident 6 on [DATE] with diagnoses which included dementia (a group of thinking and social symptoms that interferes with daily functioning), need for assistance with personal care, and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 6 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 6 required partial/moderate (helper does less than half the effort) from staff for toileting hygiene, bathing, and upper body dressing. The MDS indicated Resident 6 required supervision (oversight, encouragement or cuing) or touching assistance from staff for personal and oral hygiene. During a review of Resident 6's Order Summary Report (OSR), dated [DATE], the OSR indicated Resident 6 had a physician order, dated [DATE], to Apply pad alarm when in bed to alert staff if getting out of bed unassisted due to poor safety awareness secondary to dementia. During a review of Resident 6's Care Plan Report (CPR), undated, the CPR indicated Resident 6 was at risk of falling. The CPR indicated the facility would apply a pad alarm whenever Resident 6 was in bed. During an observation on [DATE] at 10:01 AM, in Resident 6's room, Resident 6 was observed sitting at the edge of Resident 6's bed. A pad alarm was observed hanging on the nightstand next to the bed and the on/off switch of the pad alarm was set to off. During a concurrent observation and interview on [DATE] at 11:20 AM with the Infection Preventionist (IP) in Resident 6's room, Resident 6 was sitting at the edge of Resident 6's bed. The IP confirmed the pad alarm was in the off position. The IP stated the pad alarm should be in the on position for the pad alarm to make a sound if Resident 6 attempted to get out of the bed unassisted. The IP stated the alarm was meant to alert staff to prevent Resident 6 from falling and sustaining an injury. b. During a review of Resident 7's AR, the AR indicated the facility admitted Resident 6 on [DATE] and readmitted Resident 7 on [DATE] with diagnoses which included metabolic encephalopathy (brain disease that alters brain function or structure), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7 was severely impaired in cognitive skills. The MDS indicated Resident 7 was dependent (helper does all the effort) on staff for bathing and putting on/off footwear. The MDS indicated Resident 7 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting, oral, and personal hygiene. During a concurrent interview and record review on [DATE] at 3:11 PM with the Director of Nursing (DON), Resident 7's Post-Event IDT Review (IDTR), dated [DATE] and [DATE], and Resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7's CPR, undated, were reviewed. The DON stated Resident 7 had fallen at the facility on multiple occasions since being admitted to the facility. The DON confirmed Resident 7 had fallen on [DATE] and on [DATE]. Both IDTRs after Resident 7 fell on [DATE] and on [DATE], failed to indicate any new interventions following Resident 7's falls. The DON confirmed Resident 7's IDTR, dated [DATE] and [DATE], failed to indicate any new interventions. The DON stated new interventions should be implemented to prevent further falls. The DON confirmed Resident 7's CPR was not updated following Resident 7's falls on [DATE] and on [DATE]. During a review of the facility's policy and procedure (P&P) titled, Fall Management System, revised 4/2025, the P&P indicated, It is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. The P&P indicated, Review of the fall incident will include investigation to determine probable causal factors.The investigation will be reviewed by the Interdisciplinary Team.A Summary of the investigation and recommendations will be documented in the resident's Clinical Record.Resident's care plan will be updated.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to implement its policy and procedure (P&P) titled, Labeling and Dating of Foods, and Refrigerated Storage Guide, by failing to ensure: 1. A box of orange-colored, shredded cheese was labeled with an open date, a use by date or expiration date, and labeled with what kind of cheese was in the box.2. A box of Parmesan cheese was labeled with an open date and a use by date or expiration date.3. A plastic bag which contained three (3) blocks of orange-colored cheese was labeled with a use by date or expiration date. These failures had the potential to result in food borne illnesses (any illness resulting from eating contaminated/spoiled foods) for all residents in the facility who received food from the facility kitchen. Findings: During a concurrent observation and interview on 12/31/2025 at 10:59 AM with the Dietary Supervisor (DS) inside the kitchen walk-in refrigerator, the following were observed inside the walk-in refrigerator:a) A plastic box full of orange-colored, shredded cheese labeled with a date of 12/30/25 and labeled cheese. The label with 12/30/25 on it did not indicate what the date meant. The box also did not indicate what kind of cheese was in the box.b) A plastic box of white, powdered cheese labeled with a date 11/27/25 and labeled Parmesan cheese. The label with 11/27/25 on it did not indicate what the date meant.c) A plastic bag which contained three blocks of orange-colored cheese labeled with delivered date (DD) of 12/24/25 and opened date (OP) of 12/25/25 on the plastic bag. The plastic bag did not have a use by date or expiration date on it. During an interview on 12/31/2025 at 10:59 AM, the DS stated that foods in the kitchen should be labeled with use by date or expiration date to ensure expired foods were not used. DS stated all expired food should be discarded immediately. DS stated not labeling foods with the expiration date or use by date had the potential for using the expired food and could cause foodborne illness for residents who consumed it. During an interview on 12/31/2025 at 11:25 AM with Dietary Aid (DA) 2, DA 2 stated it was important to label food with expiration date and use by date, so they would know when the food could be used by. DA 2 stated they should discard the expired food immediately to prevent food contamination. During an interview on 1/6/2026 at 1:09 PM with the administrator (ADM), the ADM stated the kitchen staff should ensure all food was labeled with use by date and prevent using expired food. The ADM stated it is important to follow these practices to prevent using the expired food and cause food contamination and food borne illnesses that can affect residents' health. During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods, dated 2023, indicated that all food items in the storeroom, refrigerator, freezer need to be labeled and dated based on established procedures for either food safety or product rotation (FIFO- First In - First Out). The P&P indicated, the Use By date will be the absolute date in which the food must be consumed or discarded by the facility. The P&P indicated, some cultured dairy products shall be discarded following the manufacturer expiration date or seven days after opening whichever comes first. The P&P indicated that for foods that are commercially processed, ready to eat, and intended to be stored cold greater than 24 hours will be marked with a Use By date. During a review of the facility's P&P titled, Refrigerated Storage Guide, dated 2023, indicated that cottage cheese, cream cheese, and soft cheese should be discarded by following expiration date or 7 days after opening, whichever comes first. The P&P indicated that hard cheese, processed cheese and loaf cheese are good for 6 months after being produced.